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ABSTRACT

This booklet focuses on the importance of national implementation of comprehensive, effective human immunodeficiency virus (HIV) education for students in school, explaining that prevention education is most effective if initiated before students start to engage in risky behaviors and is reinforced from then on. This booklet examines: "The Work of Prevention"; "Developing HIV Education" (risk behaviors, matching message to maturity, healthy sexuality and relationships, the role of self-esteem, fear and education, and teens and awareness of risk); "Barriers to Effective HIV Education"; "The Politics of HIV Education" (abstinence-based versus abstinence-only programs, research on HIV education, the role of advocacy, and family involvement and local norms); "Professional Training in HIV Education" (inservice training and psychosocial issues in teacher training); and "Model HIV Education Curricula" (elementary, middle, high school, and community-based). The booklet concludes that informed educators can contribute significantly to public advocacy for effective and comprehensive school-based HIV education. A list of resources is included. (SM)

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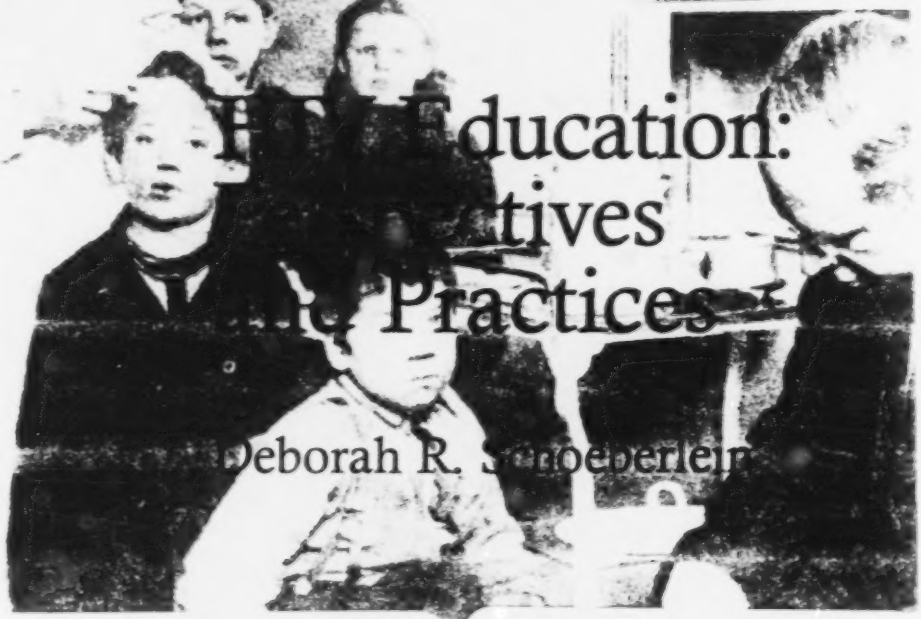

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**Deborah R. Schoeberlein**

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# HIV Education: Perspectives and Practices

by
Deborah R. Schoeberlein

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# Introduction

The AIDS epidemic will bridge the 20th and 21st centuries, as HIV continues to pose a major threat to the health and well-being of people in general and youth in particular. Medical advances in the 1990s have dramatically reduced deaths from AIDS, but not the rate of new HIV infections (U.S. Public Health Service 1998). In fact, youth are increasingly affected by HIV (Eng and Butler 1997), both directly in terms of personal risk of HIV infection and indirectly as a result of the myriad of psychosocial issues arising from the AIDS epidemic.

In the absence of a vaccine or a cure for HIV, education remains the most effective form of prevention. HIV education is among the most important contributions that schools can make to the lives of students and the future of communities. Sound methodology and demonstrated curricula validate young people's ability to make healthy choices and facilitate their development and use of prevention-related skills and strategies. The need for national implementation of effective HIV education will continue well into the new millennium.

Prevention education is most effective if it is initiated before students start to engage in risky behaviors and if it is reinforced from then on (Kirby 1997). Many youth, particularly in urban centers, are sexually active before eighth grade (Porter et al. 1996; Schwab-Stone et al. 1995). Early onset of sexual activity often predicts increased risk for HIV and other sexually transmitted diseases, or STDs (Eng and Butler 1997). HIV education can delay sexual initiation and increase risk-reduction practices (Kirby 1997).

Unfortunately, there are many obstacles to HIV education in communities across the United States. HIV prevention requires that educators and parents confront some of the most taboo subjects in modern American culture: death, sexuality, substance use, and the gray areas between public and private interests. Adequate resources, a proven curriculum, sound methodology, an understanding of adolescent development, and strong administrative support for prevention programs are all critical to the success of school-based efforts.

# The Work of Prevention

Schools present an obvious vehicle for reaching the majority of America's youth. Elementary, middle, and high schools and teacher education colleges all can contribute to school-based HIV-prevention efforts for youth through policy, programs, and community relations. Furthermore, schools can do much to support youths and families whose lives have been touched by the AIDS epidemic.

There are three commonly acknowledged levels of prevention programs: primary, secondary, and tertiary. Primary prevention, which incorporates asset-building and promotes the elimination or reduction of potential risky behaviors, is an appropriate objective for elementary and middle schools. At the middle and high school levels, secondary and tertiary prevention include "early screening and detection of high-risk behaviors to provide treatment, protection, and to prevent spread or escalation" (secondary) and "providing treatment to restore health, prevent deterioration, prevent reoccurrence, or prevent secondary complications" (tertiary) (Gingiss 1997, pp. 14-15).

Ideally, HIV educators develop and model prevention-related skills, knowledge, and commitment as well as self-efficacy, hope for the future, and perhaps the most elusive characteristic, courage. Educators, parents, and other community members can promote HIV prevention among youth by consistently reinforcing five central themes:

1. Each person should have the right to decide what to do with his or her body.
2. Each person has a right to safety.
3. Each person has a responsibility to protect others.
4. Each person should receive information about disease-prevention, including risk-reduction techniques.
5. All people should be able to access health-care services and prevention resources.

# Developing HIV Education

Public health analysis of the HIV epidemic has grown increasingly sophisticated since the early 1980s, when HIV's effects were first noticed and later identified. In the early days of the epidemic, people were categorized into high-risk groups. The legacy of these "groups" remains in the residue of stigma, shame, and discomfort that often shadows mention of HIV and AIDS.

Although the terminology of high-risk groups was convenient, the message was misleading and, in many ways, destructive. For example, being a homosexual, using injected drugs, or being Haitian carry no inherent risk for HIV. Monogamous sexual relations and consistent use of clean needles effectively limit risk in the first two "groups." And country of origin is no predictor for infection that most commonly arises from personal behavior.

## Risk Behaviors

Reliance on so-called high-risk groups was unproductive, and so the health community shifted focus to

the primacy of high-risk *behaviors* in HIV infection. The basic public-health message became more accurate and precise: It is not who you are but what you do that can put you at risk for HIV. Regardless of target audience, today we teach about HIV infection by addressing what people do, particularly with regard to sexual behaviors and sharing needles.

The same shift in theoretical framework is needed for considering children and adolescents not as risk groups, but as populations in which individuals can engage in high-risk behaviors. In other words: It is not how old you are but what you do that can put you at risk for HIV. Youths between the ages of 13 and 21 account for about 25% of all new HIV infections occurring in the United States. Fifty percent of new HIV infections are reported in people under the age of 25 (Office of National AIDS Policy 1996).

Does this mean that all young people are at high risk? No. Being a teenager in itself does not make a person more likely to get HIV. Yet, for a complex set of reasons, adolescents are disproportionately represented among those reported with new HIV infections. Often this is because adolescents lack access to comprehensive HIV education, prevention resources, and health care. Less experienced with life, adolescents also are at the low end of power imbalances with sexual partners and can find it hard to successfully negotiate prevention behaviors (Alan Guttmacher Institute 1994). Furthermore, too many teens are marginalized and without adult advocates (Hersch 1998). However, significant numbers of teens have demonstrated prevention-oriented behavior change when involved in effective HIV education in-

terventions (Kirby 1997). In addition, when compared to unmarried adults, adolescents are as proficient, if not better, users of contraception (Alan Guttmacher Institute 1994).

The likelihood of HIV infection can be understood as an equation in which the riskiness of personal behaviors interacts with other variables, such as the frequency of risky behaviors, the prevalence of HIV in the community, underlying health status, access to care, and chance. This equation can be empowering because it leads to a more factual understanding of HIV and therefore allows the individual to make better choices.

While it is possible to do something risky only once and get infected, it is the rare occurrence. Paradoxically, some people take high risks all the time and are fortunate to remain healthy. Unfortunately, probabilistic thinking — I haven't gotten HIV yet, so I probably won't — can lead to incorrect and fatalistic assumptions about personal vulnerability. Understanding the mechanism of risk as a dynamic equation is more likely to yield accurate perceptions and promote healthy behaviors.

Although the statistics about adolescents' health and behavior neither predict disaster nor justify despair, there is ample room for positive change. Sexual behaviors represent the predominant HIV infection risk for American teens (Retford 1994), the majority of whom are sexually active by 12th grade (CDC 1998). Adolescents do have high STD prevalence, as indicated by the approximately three million adolescents who contract a sexually transmitted disease each year (Eng and Butler 1997). And many teens continue to be involved in, and combine, a broad range of risky behaviors, including

substance use and abuse, violence, and sexual activity (CDC 1998).

## Matching Message to Maturity

The basic messages of HIV prevention (eliminate or reduce risky behaviors) are consistent across grade levels. However, content and presentation of these messages must be tailored for students, depending on their maturity.

Wide variation in cognitive and emotional maturity, life experience, and resilience are likely to be identified even within the distinct stages of childhood and adolescence. Children may have concerns about HIV that seem incongruent with their physical maturity and emotional development. For example, many younger adolescents report behaviors usually associated with older teens. And while older teens may know more about HIV prevention than their younger siblings, they still may resist the adoption of HIV-prevention behaviors. All of these factors must be taken into account.

Developmentally appropriate HIV education refutes the premises that children are naive innocents and that teenagers are out of control, irrational risk-takers, who are lucky if they are healthy (and alive) when they reach adulthood. While luck is part of the recipe for development, it is a small part. Children almost always know more than they are credited with knowing, and ignorance and innocence are not the same. Adolescence is a precious period in human life. As adults, we can see that adolescents are us, in our most contradictory, raw, in-

tense, searching, assertive, idealistic, and bored moments. In may ways, adolescents keep adults honest: They detect and decry hypocrisy; they remind us of our humanness. They are more than the sum of their risk and resiliency factors.

Developmentally informed HIV prevention aims to prevent high-risk behaviors and, simultaneously, to promote asset development. Peter Scales, a senior fellow at the Search Institute, writes that "researchers and practitioners working in adolescent health often make a mistake in thinking about young people, that addressing the parts — whether it be sexual behavior, substance use, or schooling — somehow would take care of the whole person" (Scales 1999, p. 113). This mistake has lead to isolated prevention programs, for example, HIV education that ignores the interconnections between a wide range of relevant topics, including human sexuality, substance use, violence, communication skills, self-efficacy, and peer pressure (Kirby 1997).

Developmentally appropriate HIV education remedies this mistake, links youths' interrelated risk behaviors, and encourages interconnected protective factors. Such strategies acknowledge the well-established links between sexual risk-taking and substance use or abuse (Retford 1994; CDC 1998) and help youths develop the skills necessary for self-awareness and self-protection.

## Healthy Sexuality and Relationships

Successful disease prevention is consistent with the development of healthy sexuality as described in the

Sexuality Information and Education Council of the United States (SIECUS) *Guidelines for Comprehensive Sexuality Education* (National Guidelines Task Force 1996). But children and adolescents frequently hear more from the adults in their lives and the media about the dire consequences of sex than about the importance of developing and experiencing healthy sexuality. It is possible that such negative messages might somehow contribute positively to youths' psychosexual development by raising awareness of realistic risks. However, it is more likely that cultural and individual attitudes that equate sex with death and align intimacy with unacceptable risk are unproductive for, if not detrimental to, adolescent development. Successful outcomes from HIV education are likely to be significantly diminished when teens' understanding of sexuality becomes heavily "loaded" with conflicting desires, fears, guilt, and shame.

HIV education for children and adolescents is fundamentally about healthy relationships and communication, issues about which educators are particularly concerned and professionally trained (Schoeberlein et al. 1999). Children and adolescents' risk of HIV infection is primarily social in nature because sexual or needle-sharing behaviors typically occur in the context of relationships. Likewise, prevention also must be inherently social: Safe(r) behaviors are learned, reinforced, valued, and sustained in relationship with other people.

## The Role of Self-Esteem

HIV education is more likely to be relevant and useful for individuals with healthy self-esteem than for those

whose sense of self-worth is weakened. Youth who are hopeless about their future and expect to be dead within a decade from violence or other unnatural causes are unlikely to be concerned about HIV prevention. The 14-year-old boy who says, "I'm gonna be dead by the time I'm 18," has little to gain from a curriculum that justifies HIV prevention by describing how HIV can kill a person in ten or fifteen years.

There are complex behavioral implications for successful HIV prevention. Individuals must understand, internalize, and remain committed to safer practices. Overly simplified HIV-prevention messages, such as "Don't have sex until you're married" or "Just say no," provide little tangible direction or support for youth who are trying to meet basic developmentally appropriate needs for intimacy, experimentation, or relationships. Children and adolescents see that the world is complicated. They know that there are many shades of gray. To be credible, curricula must acknowledge this reality and provide practical and acceptable responses.

## Fear and Education

Fear is one of the many psychosocial issues to be considered in HIV education. It is a relevant emotion for children, adolescents, and adults. Individuals have rational reasons to fear many aspects of HIV, such as infection, death, discrimination, and loss of life choices. Fear deserves appropriate attention, yet defining what is appropriate can be challenging.

Healthy fear is important and reasonable in the context of HIV/AIDS. But many youth experience


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unhealthy fear. They can express unrelated underlying anxieties in the guise of their fears of HIV and persons with AIDS. In many ways, AIDS remains a socially acceptable locus of fear. Yet it also can serve as a potent distraction from other, deeper issues. For example, a 13-year-old may state that she fears AIDS but, in fact, fears that she will not be able to protect herself sexually.

Many children and adolescents have deeply held misconceptions that are rooted in simple ignorance about the danger of low-risk activities, such as athletics or kissing. Some youth are genuinely and appropriately afraid that their parents, siblings, or friends have, or are at risk for, HIV. There are youth who fear that they already may have contracted HIV or are likely to do so in the near future. At the other extreme, some older children and adolescents lose the benefit of healthy fear as denial, optimistic bias, and personal fables replace fear and negatively affect risk-assessment and risk-taking (Maypole et al. 1998).

Youth often express their fear and anger about the AIDS epidemic through questioning why they "have to deal with HIV." If teens are angry about AIDS, they have good cause. AIDS is a disease with terrible ramifications. HIV education methods must acknowledge the validity of strong feelings of anger, frustration, disappointment, and despair. But curricula also must provide an opportunity for youth to learn that uncomfortable emotions do not inevitably lead to self-destructive risk-taking. It is developmentally appropriate for students to believe that people can feel anger about HIV and still be able to protect themselves.

Unfortunately, adults' fears of AIDS often are broadcast to youth, who frequently internalize the perceptions of those around them. Teachers and other school personnel have the professional responsibility to separate their own personal concerns from classroom performance. Parents' perceptions also can have enormous influence on children's views. As previously stated, schools can do much for students by productively including parents in HIV education programs.

Sound HIV education helps youth differentiate between productive, healthy fear and fear that is potentially destructive. Developmentally appropriate curricula address the normal changes in perceptions that accompany maturation. Teachers, administrators, health professionals, and mental health clinicians all should be aware that youth who confront their own experience with high-risk behaviors may be profoundly worried about their loved ones and often exhibit noticeable reactions during HIV education: They can act out in class, become anxious, or seem to "go numb."

Research-proven HIV education does not promote unhealthy fears among children (Schonfeld et al. 1995). A recent study suggests that "adults, including educators, the medical community, and parents, must provide information to young children about AIDS in a manner that corrects misconceptions, but respects the positive and negative contribution of fears and perceptions of vulnerability to young children's understanding" (Maypole et al. 1998, p. 126). Fear is neither good nor bad, it simply is. Youth can learn to identify, acknowledge, and accept fear. Then they can learn to transform the energy of fear into productive action or understanding.


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## Teens and Awareness of Risk

In the context of HIV education, the belief that all teens feel invincible is a problem. Some developmentally appropriate adolescent behaviors may suggest that teens think they are immortal. However, invincibility is less often the cause of these behaviors than is youth's developing capacity for abstract thought combined with their relative lack of experience with real-life consequences. With increased cognitive abilities, abstraction, and more life experience, most adolescents do learn to assign probability and profitably assess the potential outcomes of risky behaviors. But adolescents cannot be expected to mature before their time; adolescents benefit enormously from support as they pass through normal developmental phases.

It is convenient yet misguided to take graphic examples of extreme or self-destructive adolescent behaviors and extrapolate them to the whole population. While some adolescents do have misconceptions that can be understood under the rubric of invincibility, these individuals are not representative of the norm. To suggest that most teens believe themselves to be invincible is both pejorative and reductionist. Perpetuation of this myth discourages remediation. In many cases, the myth of teen's invincibility tells more about its adult proponents than about youth. Teen invincibility can be a convenient excuse for adults who are seeking to be "let off the hook" of having to communicate with teens about potentially sensitive subjects.

Many youth are highly aware of HIV and cognizant of the range of related risky behaviors. In fact, teens may


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be more accepting of the benefits and limitations of risk reduction (such as condom use) than are adults because today's adolescents have come of age with the AIDS epidemic. Teens and adults can both benefit from understanding how the messages of HIV prevention are not age-specific. They apply equally to all people who are at risk.

Although youth may respect and accept HIV-prevention strategies, young people often face barriers in accessing health care and acquiring prevention resources, such as condoms. Relatively few communities have school-based health clinics or make condoms available in high schools, much less in middle schools (Alan Guttmacher Institute 1994). In addition, states increasingly are restricting HIV education content so that schools cannot provide developmentally appropriate, accurate, and comprehensive information about condoms (Daley and Wong 1999).



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# Barriers to Effective HIV Education

Developmentally tailored HIV education works. But there are several major barriers to the delivery of school-based HIV / STD education, coordinated school health programs, and comprehensive health education (Collins 1997; Marx, Wooley, and Northrop 1998). The obstacles are varied, involve different types of constituencies, and pose numerous levels for intervention. Such barriers to HIV/STD education can be divided into several categories and include the following:

*System-level Issues*

- Schools struggle with limited financial, personnel, and other material resources.
- Implementation of effective curricular interventions is not always feasible given time constraints.

*Political Challenges*

- The conflict between abstinence-only and abstinence-based curricula has reached local, regional, and national proportions.
- Communities often are divided over the role of school-based HIV education.

- Family involvement should be an integral and productive component of school-based HIV/STD education; however, for a diverse set of reasons there are few instances where this ideal situation is the reality.
- Educators, at all levels, need appropriate support for the presentation of sensitive, potentially controversial curricula.

*Perspectives on Adolescent Development*

- The general public, as well as many professionals, continues to see adolescence as a time of psychological pathology and danger.
- In contrast, this fastback argues that adolescence is a necessary, healthy, and normal life passage, in which risk-taking plays an important role for all youth, even though some youth will have problems.

*Professional Development*

- Teachers need preservice, as well as ongoing inservice, training in HIV/STD education.
- Attention still is needed to raise awareness of the complementary nature of efforts aimed at preventing high-risk behaviors and those designed to build developmental assets (Scales 1999).

Of the obstacles listed above, the system-level issues are likely the best understood and the most obvious. As with any other education initiative, resources must be available for prevention programs. The CDC Prevention Guidelines state:

> Schools should allocate sufficient personnel time and resources to assure that policies and programs are

> developed and implemented with appropriate community involvement, curricula are well-planned and sequential, teachers are well-trained, and up-to-date teaching methods and materials about AIDS are available. In addition, it is critical that sufficient classroom time be provided at each grade level to assure that students acquire essential knowledge appropriate for that grade level, and have time to ask questions and discuss issues raised by the information presented. (Friede et al. 1997, p. 221)

As one superintendent stated with regard to teen pregnancy prevention, "We need front loading . . . . efforts must begin early, which means school districts have to bite the bullet and reallocate our resources. We must look at the budget process and our priorities and ask what is important for prevention" (Lewis, n.d., p. 4). Beyond acknowledging the importance of resources, this fastback will not focus on further explications of system-level obstacles. Instead, we will explore the other barriers to HIV/STD education and present practical responses and suggestions for successful programs.

# The Politics of HIV Education

At a national level, there is broad-based support for research-proven, methodologically sound HIV education. HIV education as a national priority is expressed in *Healthy People 2000*, which aims to increase to at least 95% the proportion of schools that provide age-appropriate HIV/STD curricula for students in fourth through 12 grade (U.S. Public Health Service 1990). Such programs are consistent with all seven of the National Health Education Standards. In particular, Standard 3 states that "students will demonstrate the ability to practice health-enhancing behaviors and reduce health risks" (Joint Committee on National Health Education Standards 1995).

The SIECUS National Guidelines Task Force also has identified several "key concepts" that pertain directly to HIV prevention. Among these are: "Sexuality is central to being human and individuals express their sexuality in a variety of ways," and "The promotion of sexual health requires specific information and attitudes to avoid unwanted consequences of sexual behavior" (National Guidelines Task Force 1996). The National

School Boards Association maintains that "clearly no knowledge is more critical than knowledge about health. Without it, no other life goal can be successfully achieved" (Joint Committee on National Health Education Standards 1995).

## Abstinence-Based Versus Abstinence-Only Programs

Development of effective HIV education programs accelerated during the 1990s. Simultaneously, national and local opposition to comprehensive HIV education, especially in the elementary and middle grades, also has grown (Gaddy, Hall, and Marzano 1996; Collins 1997). Political support and funding for abstinence-only programs, as opposed to abstinence-based programs, have increased dramatically despite the absence of credible data supporting their efficacy (National Institutes of Health 1997).

Abstinence-only curricula support risk elimination as the only way to prevent HIV. In contrast, abstinence-based approaches promote risk elimination as the safest way to prevent HIV infection but also endorse risk reduction as an important component of HIV-prevention strategies.

In many American communities, teachers and administrators must comply with state or local policies mandating or recommending abstinence-only programs (Wolff and Schoeberlein 1999). As HIV continues to spread among adolescents, these districts are restricted in their implementation of proven, abstinence-based in-

terventions. In fact, few schools implement curricula that meet existing guidelines for comprehensive sexuality education (National Guidelines Task Force 1996).

Welfare reform enacted by the United States Congress in 1997 allocated $50 million dollars annually for abstinence-until-marriage education programs. In stark contrast, the 1997 National Institutes of Health Consensus Statement, "Interventions to Prevent HIV Risk Behaviors," states:

> Legislative barriers that discourage effective programs aimed at youth must be eliminated. Although sexual abstinence is a desirable objective, programs must include instruction in safe sex behavior, including condom use. The effectiveness of these programs is supported by strong scientific evidence. (National Institutes of Health 1997, p. 28)

In the face of heated dialogue about HIV education, many schools and their communities seek to find methodologically sound, politically defensible, curricular approaches to prevention programs. Results from a 1993 survey by the Council of Chief State School Officers highlighted the importance of administrative support in facilitating the successful implementation of comprehensive school health education (Butler 1993). When solidly supported by their administrators, teachers can champion important, potentially controversial content areas. However, many teachers lack confidence in administrative support. Also, many administrators lack confidence in teachers' ability to successfully finesse the sensitive points of HIV education. In addition,


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a recent study identified lack of time and fear of controversy as the major barriers to middle-level HIV education (Wolff and Schoeberlein 1999).

## Research on HIV Education

Effective HIV education produces desirable outcomes in individuals' behavior, attitudes, skills, and knowledge, of which a positive impact on HIV risk behaviors is by far the most important. Demonstrated programs are most likely to result in desirable behavioral outcomes if they are commenced before youth initiate risky behaviors and are continued over time (Kirby 1997). Ideally, school-based HIV education begins in the elementary grades and continues through middle and high school and into higher education.

Often what appears as reckless adolescent behavior is a result of the intersection between immature abstract reasoning and lack of real-life experience. Teens need to consolidate their understanding of the world and have the time and environmental safety in which to grow. Ideally, risk-taking during adolescence has ordinary, manageable consequences, rather than irrevocable, fatal ones.

Regrettably, HIV infection brings with it extraordinary, long-term consequences. Therefore many normal risk behaviors can take on abnormally high danger. It is precisely for this reason that experiential education, with its stress on learning by doing, can make an important contribution to adolescents' psychological development. Interactive, experiential learning techniques engage students and teachers in learning

experiences that are simultaneously structured and spontaneous, free-form, and safe. Activities should explore the boundary between thinking and doing, perceiving and knowing. Experiential education, at its best, can provide a proxy for real experience. In the realm of HIV prevention, such methods are relevant and their applications appropriate.

Behavior change theory also provides important guidance for HIV education. For example, the *health belief model* posits that actions are informed by personal beliefs, including perceived susceptibility and the costs and benefits of behavior change (Rosenstock, Strecher, and Becker 1994). Fishbein's *theory of reasoned action* identifies intention as the key influence on behavior (Fishbein, Middlestadt, and Hitchcock 1994). In contrast, *social cognitive theory* presents interrelationships between social and physical environments and behavior. This theory also examines the importance of self-efficacy in behavior (Bandura 1994). Other models, such as Prochaska and DiClemente's *stages of change* (Prochaska and DiClemente 1992) and the *harm reduction model* (Single 1995) also can provide beneficial contributions to HIV education methodology.

The *Research to Classroom Project* of the Division of Adolescent and School Health (DASH) at the Centers for Disease Control and Prevention (CDC) has identified several HIV education curricula as "programs that work" with regard to behavioral outcomes (CDC 1999). The nine characteristics common to effective HIV education programs identified by Kirby and his colleagues (Kirby 1997; Kirby et al. 1994) are shown in the box.



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**Nine Characteristics Common to Effective HIV Education Curricula**

- Focus on reducing one or more sexual behaviors that lead to unintended pregnancy or HIV/STD infection.
- Use behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students.
- Incorporate theory.
- Require a sufficient length of time to complete important activities.
- Employ interactive teaching methods that help participants personalize the information.
- Provide basic, accurate information about risky behaviors as well as risk-reduction and risk-elimination practices.
- Include activities that address social pressures on sexual behaviors.
- Provide modeling and practice of communication, negotiation, and refusal skills.
- Select and train adults or peers who believe in the program.

Ideally, curricula are evaluated using experimental or quasi-experimental research designs that involve longitudinal comparisons between target and control populations. Such designs are particularly difficult to apply to school settings, where school policy may change year to year, students may not remain in the school district, and, most important, real concerns exist

regarding research involving minors, particularly involving such sensitive issues as sexuality. Nonetheless, research on the efficacy of HIV education curricula is necessary to determine the extent to which curricular methods, implementation, and effect are successful.

Of the various domains encompassed within quantitative and qualitative research, behavioral intention, actual behavior, attitudes, skills, and knowledge are the most commonly addressed. Quantitative evaluation provides for statistical analysis and permits the manipulation of variables to determine impact. Qualitative measures, which may involve open-ended questions, discussion groups, individual interviews, and other ethnographic techniques, facilitate exploration of the more subtle shades of participants' experience. Research designs combining quantitative and qualitative measures offer the most comprehensive opportunity to investigate the outcomes of specific HIV-prevention programs.

There are several levels of research and evaluation. Initially, new curricula should be pilot tested and evaluated by outside investigators. At this point, the question is, "Does it work?" Once the method is proven, it is appropriate to assess the outcomes of teacher-training initiatives. Then the question becomes, "How do we best train teachers to use this model?" Finally, teachers need assessment tools to determine student outcomes in their classrooms. In other words, "Are my students learning and internalizing the HIV-prevention messages embodied in the method?" Evaluation is important at all levels and should be ongoing, but not onerous.

## The Role of Advocacy

Given the opposition to sexuality education, there is a strong need for broad-based advocacy efforts in favor of comprehensive health education programs, coordinated school health programs, and research-proven HIV/STD education. HIV/STD prevention is multifaceted, and as such it is not necessary for all involved to possess the same area of expertise. The breadth of developmental assets provides ample room for concerned individuals to make a good fit between their own skills and activities that can support and strengthen youth (Scales 1999). HIV education is not only about sex education, and adults who are uncomfortable with sexually explicit content can work effectively with youth in such other critical and related content areas as self-esteem development, media savvy, and communication skills.

There is no single route to prevention. Classroom-based HIV education cannot produce desirable outcomes for all youth. Interdisciplinary efforts that combine school administrators, teachers, students, parents, and community members, as well as health, mental health, and social service resources, have enormous promise. For example, school health nurses can provide a range of skills and services in support of HIV-prevention programs.

Nurses can assist students in accessing existing health care services and researching health information. School nurses can assist school personnel in interpreting medical and nursing research findings to enhance student wellness. Nurses also can take an active part in

developing and implementing health curricula. Nurses play a critical role in safeguarding confidentiality regarding individuals' HIV infection and related treatment. In a more general context, the *Recommendations for the School Health Nurse in Addressing HIV/AIDS with Adolescents* also directs nurses to assume "an active advocacy role to address the health needs of adolescents" (Uris, n.d., p. 11).

The need for advocacy extends beyond such professional groups as school health nurses. Broad action is required, but many individuals and communities wonder where and how to begin. In 1997, the American School Health Association published *A Comprehensive Approach to Reduce Pregnancy and the Spread of HIV: An Advocacy Kit* to assist concerned individuals in advocating for the establishment or expansion of a comprehensive prevention program in schools (Allensworth and Rubin 1997). This kit is an important resource that can facilitate the development of local health coordinating councils or prevention coalitions that can be instrumental in building support for health programs.

## Family Involvement and Local Norms

Parents, guardians, or other family members have an important role in school-based prevention programs. Adults in parenting roles are their children's most important sexuality educators. Ideally, families instill children with their personal values, morals, and religious beliefs. Yet not all children receive healthy messages about sexuality in their homes, and not all

families are willing or able to provide children with HIV-prevention information. Consequently, schools may offer the most effective route to ensuring that all youth have access to basic, life-saving, HIV education. According to the Kaiser Family Foundation, the majority of Americans support school-based HIV education by the time children are 10- to 12-years-old (Henry J. Kaiser Family Foundation 1996).

In the best-case scenario, research-based sexuality education and HIV-prevention programs provide accurate health information in a manner respectful of students' personal beliefs. Parents and other community members are involved in HIV education curriculum adoption and enhancement. Teachers receive clear direction about their professional responsibilities and are supported by school administrators and families. Strong communication between constituencies within the school community results in integrated HIV education whose prevention messages are reinforced by a wide variety of adults and students.

Effective school-based HIV-prevention programs must both maintain pedagogical integrity and be customized to meet local norms and needs. Cultural, ethnic, racial, and religious diversity are relevant to HIV education. While some curricula are designed for specific populations (Jemmott et al. 1992), most commonly implemented models attempt to be universal. Yet educators often must adapt generic models to be relevant in the context of such local factors as widespread poverty, discrimination, socioeconomic levels, educational achievement, substance use or abuse, family dis-

ruption, youth violence, and so on. Such adaptations require an understanding of methodology and local norms. Successful customization is most likely to happen at schools that provide oversight, support, professional development, and accountability for teachers and others involved in curriculum development.

Those adults responsible for students' welfare at home, be they biological, adoptive, or foster parents, grandparents, or guardians, should be notified of upcoming HIV education well in advance of implementation. Preferably, notices should be mailed home directly or sent home with students in a contracted situation where students take responsibility for delivering the letter. Given the high potential for letters getting lost, and school getting blamed, it is not advisable to send the letters home with students without any attempt at accountability.

There are two main types of parental consent: active consent and passive consent. In active consent, the parent must give permission for the child to be included in the course. The default option is that the child does not participate. In contrast, passive consent provides parents with an opportunity to "opt-out." Passive consent typically results in higher participation rates.

School-based HIV education can do much to normalize discussion about HIV prevention. Regardless of attendance rates, schools do well to offer workshops for families or other informational presentations on HIV education. Curricula should be available for review prior to implementation.

Schools need to respect the economic and other forces that affect busy families. While many adults in parent-

ing roles cannot or do not come to hear more or learn more about the curricula, they often still want to feel more involved. Adult family members should have the option to attend an informational meeting or review the materials. Family education benefits adults as well as their children. Unlike their children, adults rarely find such education available to them. These meetings can provide adults a life-saving opportunity to increase their own understanding of HIV prevention. HIV education is a community issue, and schools can provide community service by making family education a priority.

If family members have questions or concerns about HIV-related content, they should meet directly with the teacher or school administrators. It usually is preferable to request that family members not observe their children's HIV education classes. Students often feel uncomfortable when family members are in the classroom. The class at large may also feel awkward when families are present. In HIV education, students' perception of privacy is related to their emotional safety and connected to positive student outcomes.

# Professional Training in HIV Education

Preservice teachers need specific training in HIV prevention and comprehensive health education in order to provide HIV education with success. They need to master content areas and to distinguish between their personal beliefs and professional responsibilities. They also need to learn when and how to make appropriate referrals to health, mental health, or social services.

Teachers need more than just knowledge about HIV education. Preservice training must address teachers' attitudes, perceptions, skills, and teaching behaviors. Student outcomes associated with prevention programming are likely to suffer when teachers are uncomfortable with HIV education, be it with the content, method, administrative support, or school environment.

In HIV education, the most effective curricula are challenging, interactive, and experiential and encourage spontaneous discussion. Yet despite their commitment and motivation, many teachers have not been trained to use such nontraditional methods. Therefore the methods for HIV education also deserve attention in teacher training.



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The American Association for Health Education's suggested responsibilities and competencies for elementary and middle-level health education provide helpful instructional guidelines for teachers (American Association for Health Education 1992; Breitenstein et al., n.d.). Common themes include: communicating the purposes of school health education; participating in assessment of students' health needs; planning, implementing, and assessing health education programs; and advocating for school health education. Consistent throughout the guidelines is the clear vision that health education is a critical component of school-based education for children and adolescents.

## Inservice Training

Even those teachers who have received solid preservice training in HIV/STD education can benefit from ongoing professional development. According to a 1996 report published in the *Morbidity and Mortality Weekly Report,* improvements "are needed to increase the percentage of teachers who teach HIV prevention in a health education setting and who receive inservice training on HIV prevention" (CDC 1996, pp. 763-64). A recent study of state and local education agencies identifies a high level of need for professional delivery training in middle-level HIV/STD education (Wolff and Schoeberlein 1999).

Inservice training should assist teachers in developing, adopting, and adapting methodologically sound HIV education curricula. Implementation with fidelity

is a critical issue in the success of any classroom-based intervention. Teachers should be aware of the importance of using inclusive, nonjudgmental, and respectful language when discussing HIV-related topics, especially with regard to risky behaviors. There are many important parallels between key components of other prevention programs and HIV education. Teachers who already have mastered the basics of education about substance use and abuse prevention will likely find the methodology of HIV education familiar. With a subject as potentially technical and sensitive as HIV prevention, teachers need training and ongoing support in order to maintain consistently high levels of competency and mastery.

## Psychosocial Issues in Teacher Training

Only credible teachers can become trusted messengers of HIV-prevention education. Without trusted messengers, the best HIV education curricula will fail to produce desirable outcomes. Relationships are the medium and the message of HIV prevention (Schoeberlein et al. 1999). They are where education occurs and where the results of such education must be demonstrated.

One of the most basic challenges facing HIV educators is to separate their personal beliefs from professional responsibilities. Preservice and inservice training for HIV education must address issues related to personal disclosure. Teachers must understand that it is inappropriate to share personal information or their own beliefs with students.

Confidentiality is another important component of successful prevention programs. Privacy and confidentiality are important ingredients for the development of a healthy classroom environment. But there are limits to confidentiality in classroom settings. Emotional and physical safety are both relevant to HIV education, and students have the right to expect to be safe in school settings. The distinction between confidentiality and secrecy is critical for such safety. Therefore children, adolescents, and adults alike must understand and respect the necessity of appropriate intervention when a student reveals imminent danger to self or others.

Confidentiality and other safety issues also are relevant to the professional preparation of administrators. The American Association of Colleges for Teacher Education finds that "professional preparation programs need to focus on administrators as well as on teachers and direct service providers" (Gingiss 1997, p. 22). Administrative support is critical to implementing successful classroom-based HIV education. Not only do administrators interact directly with teachers, families, and students, but school administrators also oversee the coordination of other critical health and social support services.

# Model HIV Education Curricula

Beginning in the early grades, teachers can do much to lay solid HIV-prevention groundwork for the future. Young children can learn about personal rights to safety and about community norms that promote shared responsibility for wellness. Comprehensive HIV education builds on such common issues as communication, social interaction, and emotional and physical safety.

Children both need to know and are capable of knowing different things at different ages. Yet basic HIV-prevention concepts can be connected and sequential. For example, latex gloves can be introduced to younger children as barriers between germs and bridges between people. The core, developmentally appropriate message is that wearing gloves while touching blood shows respect for personal safety and the health of another person. Later, condoms can be explained along the same lines as gloves: They are barriers that can protect people and promote respect.

The following sections identify and describe model HIV curricula for elementary and middle-level educa-

tion, as well as an overview of the curricula included in the *Research to Classroom Project* by the CDC. Important concepts are noted. These curricula are rich resources for teachers, administrators, parents, and communities seeking to promote HIV prevention among youth. Rigorous research on all of the curricula presented here has demonstrated significant, desirable outcomes. Methodologically sound, creative, and engaging, these models can be adapted to meet local norms without sacrificing curricular fidelity. Teacher training is available (see Resources) to complement the written material.

## Elementary (K-6)

*Teaching Kids About How AIDS Works: A Curriculum for Grades K-6* is a developmentally tailored curriculum that increases children's conceptual knowledge about HIV and AIDS without increasing their anxiety (Maypole et al. 1998; Schonfeld and Quackenbush 1996*a*; Schonfeld and Quackenbush 1996*b*). Developed by pediatrician David Schonfeld and Marcia Quackenbush, this AIDS-specific curriculum is theory-based and provides seven curriculum units that address the following topics: illnesses, the immune system, HIV transmission, the effects of AIDS on the body, HIV prevention, healthy choices, and feelings about AIDS.

*How AIDS Works* provides teachers with detailed lesson plans that include unit objectives, concepts, required time, vocabulary, assessment, preparation guidance, classroom activities, and family activities, as well as related activity sheets. In addition, the curriculum

provides evaluation activities for each unit. An extensive teacher resource section equips teachers with background information about HIV, review guides, content summaries, and information for parents and families. One of the most valuable components of the curriculum is its focus on child development and teacher-student communication about such sensitive issues as sexuality, death, and substance use or abuse.

Schonfeld and Quackenbush advise teachers to respond straightforwardly, without euphemisms, to students' questions on sensitive issues. Sensitive questions range from inquiries for details about sexual behaviors to questions on values and morals to issues of personal experience. Young children rarely have the capacity or experience to understand the deeper meanings of coded language, such as when an adult says someone has "passed on" (meaning the person has died). If a child asks a challenging, potentially controversial question, the teacher can do much good by acknowledging the validity of the question, addressing the query directly, and following up appropriately after class according to school policy. Particularly in elementary school, teachers do well to refer the most sensitive questions to families or other trusted adults.

HIV education is often a catalyst for disclosures of sexual abuse and other types of trauma. Children who ask for help deserve to receive appropriate assistance. Family members may not always be the right resources for such difficult questions or issues. School counselors, nurses, etc., are critical resources in these situations. It is never appropriate for school personnel to participate

in personal disclosure about their own experiences. But all personnel should be trained to respond professionally to students' self-disclosure. Curricula can provide guides on these issues, and *How AIDS Works* offers in-depth discussion on these and many other relevant points.

The curriculum identifies four basic concepts that pertain to teaching children about death: "1) death is irreversible; 2) all life functions cease completely at the time of death; 3) there are true causes why living things die; and 4) death is inevitable" (Schonfeld and Quackenbush 1996*a*, p. 250). All too often, adults try to "protect" children from knowing about death; yet children often already know about death and find adults' obfuscation confusing and contradictory. As with topics of sexuality and reproduction, children need accurate, unsensational, respectful, and developmentally appropriate information about death. They need nonjudgmental answers that do not make them feel badly about themselves or their family members. And they need a time and space to process that information with adults and peers.

Schonfeld and Quackenbush match curricular content to the stages of understanding that children pass through with regard to the causes of illness. Younger children often are egocentric and use magical thinking; they often perceive a direct connection between their actions, thoughts, etc., and the events around them. Therefore a child might think he got sick because of some wrongdoing. Although such egocentrism usually passes with age, vestiges of this type of thought are seen

in adults' understanding of illness, too. Young children also may believe that a phenomenon of an illness is its cause, in other words, you get a fever *because* you are too hot.

Yet even in preschool, many children have a basic and realistic understanding of the causes and experience of illness. The idea of germs can make sense to young students, as can the idea that the immune system protects the body. However, young students may not understand the difference between communicable and noncommunicable diseases. Young children fear diseases without being able to distinguish which types they could actually contract.

K-3 students are concrete thinkers. They interpret words literally. Thus, as Schonfeld and Quackenbush write:

> "A cold germ can get into the body," suggests to some children that illnesses are caused by a solitary germ, and that it roams around alone inside the body. They are told to cover their mouths when coughing so they will not "give" their cold to someone else. But, if they want to get rid of a cold, it seems like a good idea to leave the mouth uncovered so they can try to give it away. (1996*a*, p. 249)

It is both appropriate and important that young children learn that there are concrete, specific causes for each illness. Children can understand that germs cause illness when they get inside of a person's body. Finally, children must come to see that different germs cause different illnesses, and different illnesses have different

outcomes. Older children and adolescents can learn a great deal about the effects of germs on the body as well as the underlying causes and process of disease.

AIDS is a complicated subject, and few expert teachers are also AIDS experts. Expertise in teaching is more important to the successful outcomes of HIV education than is medical knowledge. There are likely to be many scientifically oriented questions for which teachers will not know the answer. Similarly, there may be philosophical questions that no one can answer fully, such as "How come people keep taking risks when they know how to prevent HIV?" Children need reassurance that their questions are important and that the best answers may not always be totally satisfying. Teachers and students can ponder the unknowns together. As adults, we face similar challenges and frustrations: We wish we could make the world totally safe for all children; regrettably, we cannot. Yet we can work together to try.

## Middle Grades (5-8)

EveryBody™ is a developmentally appropriate, research-based curriculum about the prevention of HIV and other sexually transmitted diseases for fifth- through ninth-grade students. Everybody™ engages young teens in active learning about HIV and other STDs. The curriculum presents 24 sequential, student-centered activities that are correlated to national science and health standards. Modular activities include guiding questions, step-by-step directions, assessment measures, and lesson extensions. Five chapters provide up-to-date

information on HIV/STDs and related topics, as well as guidance about using the curriculum.

Research shows that EveryBody™ works. It is memorable, durable, and portable (Brett et al. 1998). It is medically accurate, comprehensive, and respectful of the beliefs and concerns held by young teens, their families, and their communities. It focuses on healthy behaviors by promoting risk elimination and risk reduction strategies.

EveryBody™ posits that communication skills are critical to the successful and sustained adoption of safe, or safer, behaviors. This model focuses on communication issues. Students explore the importance of risk elimination and risk reduction by responding to such questions as, "If a person is not comfortable talking about sex, is he or she ready to have sex?" This spontaneous, free-form component of EveryBody™ is probably its most important element and undoubtedly the most difficult to implement. Teachers often benefit from specialized training and ongoing support in mastering this method.

EveryBody™ involves a booster approach of sequential classes presented to the entire student population every year. The curriculum builds on itself progressively from year to year for grades five through nine. A set progression of developmentally appropriate activities covers content related to HIV infection, transmission, and prevention and includes such topics as HIV antibody testing, risk reduction, risk elimination, and various psychosocial issues. Within this structure, there is considerable flexibility in terms of delivery and content


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adaptation. Teachers are encouraged to respond to students' particular needs and interests and to add "necessary" material. EveryBody™ is information-heavy in the early years, with greater emphasis on real-life application for the older grades.

This model communicates accurate health information in nonjudgmental, gender-neutral language. The curriculum recommends the use of clinical language to describe body parts and sexual behaviors. It presents simple definitions for vaginal, anal, and oral intercourse beginning in the fifth grade. Like *How AIDS Works*, EveryBody™ seeks to reduce children's anxiety and fear by openly identifying the most common modes of HIV infection. Youth appreciate being given complete answers. Silence about certain behaviors can easily send the dangerous message that unmentioned behaviors are safe.

EveryBody™ centers on the dual messages of risk elimination and risk reduction. These two acceptable HIV-prevention options provide adolescents with the opportunity to make their own choices. The neutral term, "risk elimination," is used to refer to the safest behaviors, instead of "abstinence," which often is associated with specific personal, political, or religious perspectives. Risk elimination refers to the absence of all behaviors that can transmit HIV. Therefore, with regard to sexual behaviors, the risk elimination message is to avoid those sexual behaviors that can transmit HIV and wait to have sex until you are in a mutually monogamous, risk-free, trusting relationship in which both partners are healthy. On the subject of sharing needles,

risk elimination means that people do not ever share needles, whether for injecting drugs, tatooing, or body piercing.

Unlike risk elimination, risk reduction is not 100% safe; but it is a valid option that provides much more safety than unprotected behaviors. Risk reduction encourages the use of such protective practices as condoms or other barriers during sexual intercourse. Also, risk-reduction strategies promote the use of clean needles, "no share" practices, and bleach kits. Teachers and students acknowledge that condoms cannot guarantee total protection. However, the curriculum does honor the research that supports the efficacy of correctly and consistently used latex condoms in preventing HIV transmission (CDC 1993).

EveryBody™ addresses interrelationships between substance use or abuse and sexual activity. Students identify direct and indirect links between HIV transmission, the consumption of alcohol, and the use of psychoactive drugs and anabolic steroids. HIV transmission is clearly linked to shared drugs or drug use paraphernalia (Koester 1998). However, alcohol and other drug use can affect teens' behavior in ways that are likely to increase the risk of HIV infection. For example, drinking and sex rarely mix safely. EveryBody™ explores the influence of peer norms, power issues, and social pressures in HIV prevention.

EveryBody™ activities are experiential and resemble performance art more than they do traditional health education "games." The curriculum is informed by the premise that HIV prevention must be learned both in

the mind and by the body. The experiential education theme is particularly powerful for children and adolescents, given their cognitive development and changing capacity for abstract thought. Effective communication in an open, safe, nonjudgmental context permits more effective transmission of curricular content.

## High School Curricula and Community-Based Programs

As of summer 1999, five HIV-prevention curricula for adolescents were included in the CDC's Research to Classroom Project:

- Reducing the Risk
- Get Real About AIDS
- Be Proud! Be Responsible!
- Becoming a Responsible Teen
- Focus on Kids

Of these, four curricula are recommended for use with students aged 13 to 18, and one is for youth nine to 15 years old. These curricula are effective and share the common characteristics of successful programs as identified by Kirby (1997). However, these programs also represent a wide range of methods. Time requirements vary from 17 class periods to five hours. Most are designed to be school-based, though Focus on Kids is a community-based model. Three of the five curricula target African-American youth and other youth in urban, low-income areas. Additional information about these programs can be found in the Resources section of this fastback.

# Conclusion

Informed educators can contribute significantly to public advocacy for effective and comprehensive school-based HIV education. Organized political support for comprehensive health education and coordinated school health are critical to the development and implementation of successful HIV-prevention strategies. Teachers, administrators, and school communities can do much to promote school-based HIV-prevention programming. Given opportunity, guidance, and developmentally appropriate curricula, students can learn and maintain healthy behaviors. They can change unhealthy patterns. They can prevent HIV infection.

If HIV education is to bridge the 20th and 21st centuries successfully, everyone must build on the lessons already learned and take the risks necessary to span present and future challenges. Educators and families will need to demonstrate a greater level of commitment to the implementation of prevention programming than they have previously. The fields of public health and education are well equipped for this effort. The foundations have been laid, scaffolding established, and the materials are available. Even more important, there are

skilled individuals capable of doing the work. However, a common vision has yet to emerge, and the political will for such work must be raised.

AIDS is no longer the epidemic *du jour.* Complacency can kill. There remains much to be done. As educators, we must model what we teach, and we must do so with courage.



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# Resources

**Elementary and Middle Level Curricula**
*How AIDS Works: A Curriculum for Grades K-3*
*How AIDS Works: A Curriculum for Grades 4-6*
ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061
1-800-321-4407

EveryBody™
RAD Educational Programs
P.O. Box 1433
Carbondale, CO 81623
(970) 963-1727 (for professional development programs)
1-800-936-4443 (for ordering EveryBody™)

**High School Curricula and Community-Based Programs**
The following curricula are identified as Programs that Work in the Research to Classroom Project by the Division of Adolescent and School Health at the Centers for Disease Control and Prevention.

- Reducing the Risk
- Get Real About AIDS


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- Be Proud! Be Responsible!
- Becoming a Responsible Teen
- Focus on Kids

These curricula are available from:
*Be Proud! Be Responsible!*
Select Media, Inc.
225 Lafayette Street, Suite 1102
New York, NY 10012
1-800-343-5540

*Get Real About AIDS*
Altschul Group Corporation
1560 Sherman Avenue, Suite 100
Evanston, IL 60201
1-800-323-9084

*Reducing the Risk*
*Becoming a Responsible Teen*
*Focus on Kids*
ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061
1-800-321-4407

**Print Resources**

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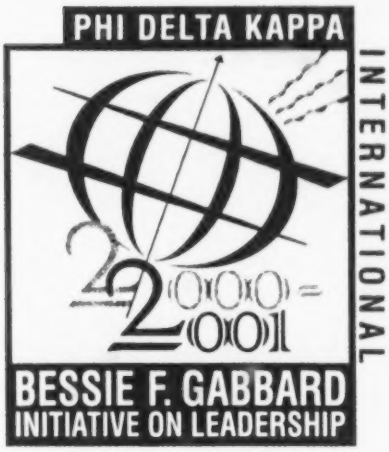


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*The nurse's fashionable hat adds an interesting note to this 1912 school dispensary scene. She looks after a bruised forehead while the doctor takes care of a skinned shin.*

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